State of Hawaii
Department of Human Services
Social Services Division

Addendum No. 1

May 11, 2015

to

Request for Proposals (RFP)

SSD-15-POS-2050

DOMESTIC VIOLENCE SERVICES FOR FAMILIES

STATEWIDE

RFP Posting Date: April 19, 2015

PLEASE NOTE:
RFP Proposal Submission Deadline has been changed from May 18, 2015 to May 21, 2015, 4:30 p.m. Hawaii Standard Time

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SSD-15-POS-2050

DOMESTIC VIOLENCE SERVICES FOR FAMILIES

The Department of Human Services, Social Services Division, Child Welfare Services Branch is issuing this Addendum to add additional information and correct/revise the RFP as detailed below.

If you have any questions please contact:
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RFP Written Questions and Responses

Note: The Section and page references of the responses in this section of the Addendum #1 pertaining to 2.4, B. Service activities and 2.5 Compensation and Method of Payment in the RFP were referenced according to the attached revised versions of these sections, currently pages 2-10 – 2-16 (previously pages 2-10 – 2-15) and pages 2-22 – 2-24 (previously pages 2-21 – 2-23), respectively. Also, due to the 2.5 Compensation and Method of Payment revisions, the page numbers for the Performance Measurement Forms A, B, and C in the RFP were revised to the current pages 2-25 – 2-29 (previously pages 2-24 – 2-28).

1. **Proposal Submission Information Sheet** (Pages 2-3) and **1.1 Procurement Timetable** (Page 1-1)

   Question: Would the DHS please consider extending the RFP application deadline?

   Response: Due to the number of corrections/revisions made to this RFP as well as the number of attachments just being made available in this Addendum #1, **the DHS has changed the Proposal Submission Deadline to May 21, 2015, at 4:30 p.m. HST.**

2. **Proposal Submission Information Sheet** (Pages 2-3)

Question: According to the discussion during the RFP orientation (4/30/15) regarding the provision of certain application documents in Word/Excel format--other than narrative, work plan, and budget forms--are there other documents within the application that should be provided as either a Word or Excel document? Please identify. The concern here is that we, the Applicant, may not know which other documents DHS needs in Word/Excel, not provide them, and then be marked down for not providing them in the electronic version of our application to you.

Response: The Applicant must submit printed copies of the proposal as well as electronic copies of the proposal in PDF and Word/Excel formats. The Applicant may submit the complete proposal in Word/Excel format, as applicable, **or** all of the following parts of the proposal in Word/Excel format, as applicable: **Narrative, Performance Measurement Forms A, B, and C, Work Plan, Organization and Program Charts, Job Descriptions (no resumes), and Budget forms**. The proposal must be submitted in all of the required formats or it cannot be accepted/reviewed.

3. **2.1, D. Description of the target population to be served** (Page 2-3)

Question: Are community or self-referrals to the RFP services allowable (i.e. will they be paid for by these funds)?

Response: No, the target population to be served is limited to families referred by Child Welfare Services (CWS), Voluntary Case Management Services (VCM), and Family Strengthening Services (FSS). Community or self-referrals will no longer be covered under this contract.

4. **2.1, E. Geographic coverage of service** (Pages 2-3 - 2-5)

Question: Is it the Department's intention/direction to award one (fewer) contract(s) to a Provider for services statewide? Or some version of the desire to award fewer contracts for these specialized services? By requiring that the Applicant must provide services to all members of the family, it appears to be the impression.

Response: The DHS intends to award one contract in each of the nine geographic areas identified to improve service coordination for survivors, children, and batterers. Applicants are encouraged to subcontract with other Applicants, as necessary, to provide an array of services to families, including culturally specific programming.

5. **2.2, C. Multiple or alternate proposals** (Page 2-6) and **3.4 Service Delivery** (Page 3-5)

Question: Page 2-6 states that multiple proposals shall be allowed. However, on page 3-5 it states, "The Applicant may submit only one proposal, however, shall include separate, detailed program information for each service group in each geographic area the Applicant proposes to service. Factors such as each geographic area's population and needs, each proposed program's capacity, the available community resources in each geographic area, and the Applicant's ability to collaborate with community agencies and supports in each area shall be included in the proposal." Can there be multiple proposals submitted for each geographic location or only 1 proposal encompassing all locations?

Question: Please verify that only one application should be submitted even if an Applicant intends to submit proposals for multiple geographic areas (per RFP, p. 3-5, NOTE).

Response: The Applicant may submit either one, separate proposal for each geographic area or one proposal for all geographic areas. However, for that option, separate, detailed, information must be submitted for each service group (survivors, children, batterers) in each geographic area such as population and needs, program capacity, available resources and services, ability to collaborate in the area, facility information, staffing, project organization, service delivery, budget, etc. Alternate proposals for one geographic area are not allowed.

6. **2.4, B., 1., d. Case management** (Pages 2-11 - 2-12) and **2.4, C., 3., f. and g. Personnel** (Page 2-16)

Question: What is the minimum educational level for a staff person to provide Case Management? According to the RFP, page 2-16, one might infer a high school degree or GED is the minimum since Case Management is categorized as a Support Service (RFP, page 2-13, c., 1) Support Services). However, in general social work practice, a Bachelor's degree is typically the minimum educational requirement. Please clarify.

Response: Individual services were revised to include Case management (and Intake). Additionally, the minimum educational requirement to provide Case management services was revised to a Bachelor's degree.

7. **2.4, B., 3. Support services** (Page 2-14)

Question: Is transitional home (living) an allowable expense?

Response: Transitional housing expenses will not be allowable under this contract, however, referral/linkage to housing programs, including transitional housing programs, may be appropriate.

8. **2.4, B., 4., 2) Family counseling** (Page 2-15)

Question: Please define or describe "family counseling" (RFP, page 2-14, d., 2) Therapeutic/Clinical counseling services), including who will determine (DHS or Provider) when it is "safe" to initiate family counseling? Our concern is that family counseling is not best practice in the domestic violence intervention field.

Question: Family counseling is considered poor practice. How does the DHS envision Providers offering this service in the face of best practice principles?

Response: Family counseling is not intended to be the primary mode of treatment for families, however, it may be provided as determined appropriate by the referring worker and the Provider and when survivors and children feel safe. This was included as a treatment option when determined appropriate upon a batterer's completion of a BIP, when a family is intact, or if reunification is planned, and/or for survivors and children.

9. 2.4, B., 4., 3) Therapeutic visitation (Page 2-15)

Question: Please define or describe "therapeutic visitation" (RFP, page 2-14, d., 3) Therapeutic/Clinical counseling services), including DHS' expectations of what kind of setting "therapeutic visitation" services should provide and what should be the minimum educational level of the Provider's staff.

Response: Therapeutic visitation is supervised visitation with a therapeutic component. It should be provided by a Master's degree counselor as a component to family counseling to support appropriate interactions between children and their parents, which may include the survivor when children are removed from the family home and supervised visits are ordered. As specified under 2.4, B. Service activities (page 2-10), services may be provided at program facilities, the homes of survivors/children/batterers if determined safe and appropriate by referring workers and the Provider, or other safe places in the community.

10. 2.4, C., 3., i. Personnel (Page 2-16)

Question: Should waiver requests for staff who do not meet the minimum educational qualifications (RFP, p.2-16, item i) be prepared and sent along with the Proposal Application or afterwards, only upon award of the contract?

Response: Requests for waivers of qualifications for staff who currently do not meet the minimum educational qualifications are not required to be submitted with the Proposal Application. However, if the Applicant is awarded a contract the requests will be required to be submitted prior to contract execution.

11. 2.4, C., 4., 5) and 6) Training plan (Page 2-18)

Question: Will DHS provide training and/or pay for training to the Provider for items 5 and 6 in the RFP on page 2-18, 4. Training plan, b., 5) and 6)-- i.e. an

overview of CWS/VCM/FSS, including mandated reporter responsibilities, and services offered by the DHS BESSD and Med-QUEST Divisions and how to access these services?

Response: Training in the above areas is not routinely provided by the DHS. However, please see the two attachments to this Addendum #1, Hawaii Differential Response System Overview and the Case Flow Chart, which may be helpful. General information is also available online at the following addresses:

Differential Response System Powerpoint:
http://www.nrccps.org/PDF/HI_Differential_Response_Presentation4-4-05.pdf

Mandated Reporter Guide 2015:
http://humanservices.hawaii.gov/ssd/files/2015/04/Guide_2015.pdf

Hawaii Mandated Reporting Film:
https://www.youtube.com/watch?v=2R7jKB96is0

TANF Brochure:
http://humanservices.hawaii.gov/bessd/files/2015/01/TANF-Brochure-2015.pdf

Hawaii Financial and SNAP Benefits Rights and Responsibilities:
http://humanservices.hawaii.gov/bessd/FNSRandR/

Department of Human Services, Med-Quest website:
http://humanservices.hawaii.gov/mqd/

The Provider may also contact the DHS BESSD and Med-QUEST Divisions directly to inquire whether informational sessions are available.

12. **2.4, C., 8. Output and performance and outcome measurements** (Page 2-20) and **Performance Measurement Forms A, B, and C** (Pages 2-25 – 2-29)

Question: Can DHS provide Forms A, B, and C in Word format?

Response: The Performance Measurement Forms A, B, and C have been revised (see Question #13) and added in Word format as a separate attachment to this Addendum #1 so that the Applicant may complete them more easily.

13. Question: Can Form B, Service Activities (RFP, p. 25) be revised to group the service activities according to batterers, survivors, and children?

Response: Yes, the Performance Measurement Form B headings have been revised to reflect the headings "Survivors," "Children," and "Batterers" (see Question #12).

14. Question: Could DHS provide a breakout estimate of the number of services anticipated for each of the service activities listed in Form B (RFP, page 25) by geographic area and/or family member (survivor, child, batterer)?

Response: The DHS is unable to provide an anticipated number of services for each service activity as this information was not captured during the current contract period and is therefore not available.

15. **2.5 Compensation and Method of Payment** (Pages 2-22 – 2-24)

Question: What would the 60/40 split look like? Are you going by units (hours) served or by the number of clients served to get the 40% return?

Response: This section has been revised and is attached.

16. **Section 3, Proposal Application Instructions** (Page 3-1)

Question: If we are only allowed 1 proposal, will the page limitations for each section that needs to be addressed geographically be per geographic area? For example, the Project Organization and Staffing section has an 8 page limit. If we were to apply for 7 locations, would the 7 locations we are describing each have 8 pages? Then the same thing for Service Delivery: each of the 7 locations, if they are running the program tailored to their community, then each location would have a Service Delivery section with 15 pages?

Question: Is it allowable to use the preferred page maximum for the narrative sections (RFP page 3-1) as guidance for each section per geographic area, where information will vary for the geographic area? For example, if an Applicant is applying for two geographic areas, then would we be able to draft up to a maximum of 16 pages for the Project and Organization section (maximum 8 pages per geographic area)?

Response: Yes, the recommended page limits apply to each section for each geographic area included in the proposal. The Applicant should include any information it deems necessary to include in its proposal, even if the page limits are exceeded, if that assists in their ability to convey the required information. However, the Applicant should be discriminating regarding the amount of pages included in its proposal and not overly exceed the recommended page limits. No points will be deleted for exceeding the recommended page limits.

17. **3.4 Service Delivery** (Page 3-4)

Question: Please provide a template of the Work Plan that DHS would like Applicants to use (RFP, page 3-4 to 3-5).

Response: The Work Plan referred to in this paragraph has been added as pages 5-55 – 5-59 in Section 5 of the RFP and posted as a separate attachment to this Addendum #1 so that the Applicant may complete it more easily.

18. 3.3, B., 2. Project Organization (Page 3-4)

Please clarify how you want the organization charts to read. The RFP says to detail each staff position budgeted to the contract including:

a. The position title
b. The minimum qualification level
c. FTE to the program
d. Lines of supervision.

Do you want the position title and name of the incumbent, if available, and to list if the position is vacant or not? Do you want the minimum qualifications required based on the job description and/or the minimum qualifications of the incumbent, if available? Or do you want 2 different organization charts with the information listed in the RFP and a separate one with the names of incumbent staff and their qualifications?

Response: The Applicant should include the job position's title, the minimum qualifications based on the job description, the job position's FTE to the program, and the job position's line/s of supervision. **Job position descriptions and job vacancy information should also be included in the proposal.** Resumes and incumbent staff information may be requested, as necessary, if the Applicant is awarded the contract. Submission of education/experience and/or criminal/CWS Central Registry waivers for incumbent staff for whom waivers were not previously approved by the DHS will be requested if the Applicant is awarded the contract.

19. 3.5, A., 4. Pricing structure (Page 3-8)

Question: The instructions call for a "separate administrative" budget. Do you want a second packet of SPO-H forms or a separate column on the same forms with the direct program expenses and a "totals" column?

Response: Yes, the Applicant should submit a separate Administrative Budget on SPO-H 205 and SPO-H 206A through J forms, as applicable, found on the SPO website.

RFP Corrections, Revisions, and Comments

1. 2.4, B., 5. Dispute/conflict resolution (Page 2-15)

This section was added as follows (see attached revised 2.4, B. Service activities).

2. **2.4, C., 7., a. Reporting requirements for program and fiscal data** (Page 2-19) The existing 2) became 3).

A new 2) was added as follows:

The Provider shall complete the quarterly Limited English Proficiency (LEP) Report in the format provided by the DHS. The Provider shall report the number of parents and children who were offered and who received language access services, the type of language access service provided, the type of service provider used, and the expenditures spent on language access services during the reporting period.

A third sentence was added to 3) as follows:

The LEP Report shall be submitted to the DHS via email by the last day of the month following the reporting period.

3. **2.4, C., 7., b., 1) Reporting requirements for program and fiscal data** (Page 2-19 – 2-20)

The second sentence was revised as follows:

The Provider shall summarize its annual projected program and personnel expenditures as well as report the actual expenditures of contract funds during the reporting period for which an invoice will be submitted.

A sentence was added to the end of the same paragraph as follows:

Expenditures reported in the Expenditure Report shall be subject to review by the DHS, such as a review of all applicable receipts, to verify the amounts and the appropriateness of the reported expenditures.

4. **Section 5, Attachments** (Pages 5-1 – 5-54)

The documents from Section 5 that need to be included in the proposal are the **Proposal Application Identification Form, Proposal Application Checklist, Special Conditions, and Administrative Assurances**. All of these forms need to be completed and signed.

B. Service activities

Service referrals shall be made by CWS/VCM/FSS. Families, survivors, and batterers shall be allowed to select a Provider from a Provider list that includes a summary of a Provider's services, their location/s, and their services schedule. If a Provider is not selected, a referral for the family, survivor, and/or batterer shall be made to a Provider in the same geographic area or a Provider deemed to be the most advantageous to the family, survivor, and/or batterer.

Service activities shall not duplicate those provided under any other contract without the prior written approval of the DHS.

Services for children may require contact with survivors or adults responsible for their care and supervision, such as relatives or resource caregivers.

Services may be provided at program facilities, the homes of survivors/children/batterers, if determined safe and appropriate by referring workers and the Provider, or other places in the community. The selected location shall provide for safe, confidential, and appropriate interactions between survivors/children/batterers and staff.

The Provider shall have written procedures for the service activities detailed below:

1. Individual services

    a. Intakes
    The Provider shall receive all referrals and have a process to complete intakes with survivors/batterers, including contacting referring workers to obtain information, as necessary. Intakes may be completed over the phone. The Provider shall have applicable criteria for referred survivors/children/batterers for admission/non-admission to the program.
        1) The Provider shall initiate attempts to contact survivors/batterers in order to complete intakes and schedule assessments within three (3) working days of the receipt of the referral. If this timeline is not met, the Provider shall document its efforts and the reasons, such as the lack of response by a survivor/batterer, and notify the referring worker in writing.
        2) If the Provider has difficulty contacting or locating a survivor/batterer, the Provider shall request the assistance of the referring worker.
        3) The Provider shall notify referring workers in writing within three (3) working days of admission/non-admission to the program.
        4) The Provider shall maintain copies of intake documentation and any notifications to referring workers in case files.

5) In the event of a crisis/emergency, a referring worker may request and facilitate an expedited assessment appointment by contacting the Provider by telephone in the presence of the survivor/batterer. The written referral shall be submitted to the Provider on the same day.

b. Assessments
   1) The Provider shall complete face-to-face, comprehensive, domestic violence assessments for survivors/children/batterers admitted to the program within two (2) weeks of the receipt of the referral. If this timeline is not met, the Provider shall document its efforts and the reasons, such as the cancellation of an appointment by a survivor/batterer, and notify the referring worker in writing.
   2) Assessments shall evaluate an individual's strengths and needs to inform service and safety planning and include a dangerousness assessment for survivors and a lethality assessment for batterers.
   3) The Provider may be required to use specific assessment tools as determined by the DHS.
   4) The Provider shall send copies of assessments to referring workers within one (1) week of assessment appointments.
   5) The Provider shall maintain copies of assessments and any notifications to referring workers in case files.
   6) Services determined appropriate in assessments shall commence within one (1) week of assessment appointments. If this timeline is not met, the Provider shall document its efforts and the reasons, such as the cancellation of an appointment by a survivor/batterer, and notify the referring worker in writing.

c. Crisis/emergency intervention services
   1) The Provider shall provide these services to survivors/children/batterers as needed, including, but not limited to, written emergency safety planning and "warm" linkages to recommended services such as domestic violence shelters, medical/mental health programs, Temporary Restraining Order (TRO) assistance, and legal services.
   2) The Provider shall maintain documentation of crisis/emergency services in case files.

d. Case management
   1) The Provider shall provide case management services for survivors/children/batterers participating in the program.
   2) Services shall include referrals/linkages to community agencies and supports such as medical/mental health services, substance abuse services, housing, financial supports, employment, child care, TRO application assistance, legal assistance, education/training programs, etc.
      a) Due to their often complex/confusing nature, referrals to health/mental health care services shall be facilitated, as needed. If there are service costs, medical insurance, if

applicable, or other resources shall be explored to assist in paying for them. The Provider shall help survivors/batterers understand what kind of medical insurance proposed health/mental health care providers accept and what survivors'/batterers' medical insurance covers, including coverage for children, by facilitating their contact with the health/mental health and medical insurance providers.

3) The Provider shall provide service coordination/collaboration with other community agencies that provide appropriate services and supports to help meet the needs of survivors/children/batterers. This includes, but is not limited to, domestic violence shelters, health/mental health service providers, housing assistance programs, financial assistance programs, survivors service providers, BIPs, and domestic violence coalitions and task forces.
4) The Provider shall provide case status reports (e.g. verbal updates, periodic summaries, etc.) to referring workers on survivors'/children's/batterers' progress as requested.
5) The Provider shall maintain documentation of referrals/linkages, service coordination/collaboration, and case status reports in case files.

e. Safety planning
   1) The Provider shall complete written, comprehensive safety plans with survivors and children, as appropriate, within two (2) weeks of assessment completion.
   2) Safety plans shall address the needs of survivors/children together or individually, as appropriate.
   3) The Provider shall provide copies of safety plans to survivors/children in a manner which supports their safety.
   4) The Provider shall maintain copies of safety plans in case files.
   5) The Provider shall complete written emergency safety plans at intakes or assessments, as applicable.

f. Service planning
   1) The Provider shall complete individualized service plans for all survivors/children/batterers within two (2) weeks of assessment completion.
   2) Service plans shall be based on assessments, needs identified in referrals, and individual input.
   3) The Provider shall review and updated service plans monthly or as necessitated by changes in individual circumstances.
   4) The Provider shall send copies of service plans to referring workers within one (1) week of completion.
   5) The Provider shall maintain copies of service plans in case files.

g. Discharge planning
   The Provider shall have applicable criteria for both termination from services and completion of services for survivors/children/batterers.

1) The Provider shall notify referring workers in writing within three (3) working days of a survivor's/child's/batterer's service termination.
2) The Provider shall complete written discharge plans for all survivors/children/batterers completing services at least two (2) weeks prior to service completion, including a summary of services provided and community agencies and supports currently in place.
3) The Provider shall send copies of discharge plans to referring workers within one (1) week of completion.
4) The Provider shall maintain copies of terminations, discharge plans, and any notifications to referring workers in case files.

h. Individual sessions
1) These sessions may be provided, as necessary, to identified survivors/children/batterers to augment group curriculum and/or to address crisis/emergency or other individual situations that impede their achievement of identified goals.
2) The Provider shall maintain documentation of individual sessions in case files.

2. Group services

a. Survivors groups shall provide:
1) A safe place for survivors to share and understand their experiences.
2) Evidence-based curriculum on the dynamics of domestic violence, including, but not limited to, the cycle of abuse, power and control indicators, the impact on survivors and children, and how to support children through their trauma.
3) Safety planning concerns and strategies.
4) Information on community resources and supports.
5) Education on child development, as appropriate.

b. Children's groups shall help children understand:
1) That domestic violence is not a child's responsibility.
2) The meaning of safety planning and what children can do to be safe.
3) The physiological (e.g., agitation, hyper-vigilance, or nervousness) and emotional effects of trauma and what children can do to deal with them.
4) The importance of sharing feelings, needs, and experiences with others and what children can do to improve communication.
5) The importance of positive social interactions with peers and others and what children can do to develop and maintain them.
6) Dating violence indicators and interventions for youth, as appropriate.

c. BIPs groups shall follow the guidelines in the current "Hawaii Batterers Program Standards" (http://www.ncdsv.org/images/HI_BIPS-Standards_December2010.pdf) and:
   1) At minimum be conducted for two (2) hours per week for 24 weeks.
   2) Be facilitated by two (2) facilitators, one of each gender, and service the recommended maximum number of 16 – 18 participants, unless otherwise designated or approved by the DHS. In groups with only one facilitator, the recommended maximum number of participants shall be 12-14 participants.
   3) Utilize recognized, effective "best-practice" interventions, based on current knowledge and research, and presented in gender relevant and culturally appropriate ways.
   4) Include identification of batterers' criminogenic risks/needs, which will be addressed in the curriculum.
   5) Provide batterers the knowledge and skills needed to reduce and eliminate coercive, controlling, dominating, and violent behaviors, which should help increase the safety of survivors and children.
   6) Help batterers learn socially acceptable alternatives to violence through effective communication, coping strategies, problem solving, and behavioral management skills.
   7) Provide batterers opportunities for skills practice.
   8) Address batterers' violence and its negative impact on survivors and children, including focusing on batterers' behaviors and not blaming survivors.
   9) Include a component to address/enhance the safety of survivors and children; this shall include contact with survivors to determine risk, provide program information, and provide referrals to survivors' support and other services, as needed.

d. The Provider shall maintain documentation of all groups in case files.

3. Support services

The support services detailed below shall be provided to survivors/children/batterers, as needed, to enhance survivors' and children's safety and to promote positive behavioral changes by batterers:

1) Program and/or public transportation (e.g. physical transport by the Provider, bus fare, bus pass, etc.) to access the Provider's and/or other necessary services and supports if transportation is not otherwise accessible.
2) Individual and/or group childcare to allow survivors/batterers access to the Provider's services and/or other necessary services and supports if childcare is not otherwise accessible.
3) Supervised child/ren exchanges/visitation.
4) Advocacy to support and empower survivors/children/batterers in achieving their goals.

5) Assistance for survivors with completing a TRO application if assistance is not otherwise available.
6) Outreach services, if determined by referring workers and the Provider that more intensive services are not required or if more intensive services have already been completed, including, but not limited to:
   a) Regular home visits.
   b) Hands-on parenting instruction, as necessary.
   c) Practical life skills education on nutrition, budgeting, etc.
7) The Provider shall maintain documentation of all support services in case files.

4. Therapeutic/Clinical counseling services

Counseling shall be provided on a short-term basis (six (6) sessions), unless more sessions are approved in writing by the DHS, if determined necessary by referring workers and the Provider. Counseling shall enable survivors/children/batterers to gain insight into their feelings and behaviors, enhance their coping strategies, facilitate behavioral changes, and improve their relationships. Services shall include:

1) Individual counseling.
2) Family counseling as determined appropriate by referring workers and the Provider and when survivors/children feel safe. This may be appropriate upon a batterer's successful completion of a BIP, when a family is intact, and/or when reunification is planned. Family counseling may also occur between children and survivors/batterers, including strengthening bonding between infants/toddlers and parents.
3) Therapeutic visitation shall be provided by a qualified counselor as a component of family counseling to support appropriate interactions between children and parents.
4) The Provider shall maintain documentation of therapeutic/clinical counseling services in case files.

5. Dispute/conflict resolution

The Provider shall have in place dispute/conflict resolution procedures to address potential disagreements between survivors/children/batterers and the Provider as well as community resources and the Provider. The Provider may need to consult with referring workers when such conflicts/disputes arise.

6. Service transitions

The Provider shall ensure appropriate service transitions for survivors/children/batterers to other Providers, community agencies, and supports, as applicable, before the contract ends.

7. Community education and training

The Provider shall participate in educating and training the community about domestic violence and services related to survivors/children/batterers. Presentations shall include a description of the primary services available in the geographic area/community serviced and be culturally sensitive to the various ethnicities/cultures within the geographic area/community.

HAWAII DIFFERENTIAL RESPONSE SYSTEM OVERVIEW

Differential response is a process that assesses each report to Child Welfare Services (CWS) to determine the most appropriate, most effective, and least intrusive response that can be provided by CWS or our community partners to a report of child abuse or neglect.

Federal Child Abuse Prevention and Treatment Act (CAPTA) Requirements --

CAPTA requires "...establishment of a triage system that:

(A) accepts, screens, and assesses reports received to determine which such reports require an intensive intervention and which require voluntary referral to another agency, program, or project;
(B) provides, either directly or through referral, a variety of community-linked services to assist families in preventing child abuse and neglect; and
(C) provides further investigation and intensive intervention where the child's safety is in jeopardy." (Section 105(2) amended June 25, 2003)

INTAKE

Hawaii's differential response process starts with a report to the CWS Intake Hotline (24/7). Intake Social Workers assess the reports, using a standardized intake assessment, to identify appropriate responses for families with children who have been maltreated or are at risk of maltreatment. Particular emphasis is placed on a determination at intake of whether a report presents a risk or safety concern and what level of risk exists at intake, based on the information that is available from the reporter, collateral contacts and other sources of information such as the Department's central registry.

Safety vs. Risk

When a report is received, the Intake Social Worker will make an assessment of whether the report presents a safety or risk concern by using the intake assessment tool. If the report identifies a safety factor, or high risk factors that place the child at risk of substantial/imminent harm, the case will be assigned to CWS for an investigation, further assessment and action.

If a case identifies low to moderate risk factors and no safety concerns, the family will be referred for voluntary services with either Family Strengthening Services (FSS) or Voluntary Case Management Services (VCM), depending on the level of risk identified. **Cases identified with Low/Moderately Low Risk will be referred to FSS and cases identified with Moderate/Moderately High Risk will be referred to VCM.**

In addition to identifying risk factors, protective factors and family strengths are also identified at the point of intake. Intake Social Workers consider these factors when

assessing the overall level of risk for a case, in order to make the most appropriate referral for services.

FSS and VCMS

- FSS – For reports/cases assessed as presenting low risk of harm to a child or children. FSS services include assessment, service planning, short-term counseling and intervention and development of a family's resources, and will be provided for up to six months.

- VCMS – For reports/cases assessed by CWS as presenting moderate risk of harm to a child or children. VCM services include assessment, case planning, monitoring and counseling, and can be provided to in-home cases for up to 12 months.

Inter-Agency Coordination

To ensure coordination between the VCM programs and CWS, a Voluntary Case Liaison (VCL) employed by CWS is co-located with each VCM programs. The VCL will input case logs and service lines into the Child Protective Services System (CPSS) and provide case consultation to the VCM Programs" Case Managers. The VCL, while housed with the VCM provider, will be supervised by the Department's Section Administrator or designated supervisor for the geographical area served by the VCM program.

Work is in progress for VCM and FSS to have direct access to CWS Information System -- SHAKA (State of Hawaii Automated Keiki Assistance) – in 2009.

REFERRAL PROCESS

The table below outlines the possible referral paths for services:

	Referral Source			
Risk Level	**Intake**	**CWS Assessment**	**VCM**	**FSS**
Low Risk	FSS	FSS	FSS	--
Moderate Risk	VCM	VCM	--	CWS
High Risk/ Safety Concern	CWS	CWS	CWS	CWS

CWS Assessment Social Workers and FSS/VCM Providers use the same **Safety Assessment** and **Comprehensive Strengths and Risk Assessment** tools in determining whether cases can be appropriately referred to FSS or VCM services or should be returned to CWS for services. **Families referred to VCM have full access to all CWS contracted services.**

All VCM and FSS families on Oahu have full access to Access to Recovery (ATR)

Support services (e.g., child care, transportation, housing, cultural and spiritual support, and sober support activities), funded by a 3-year SAMSHA grant to specifically assist families involved with CWS.

- If a VCM or FSS provider assesses that high risk or safety concerns exist for a family, the case is returned to CWS for further investigation and/or the filing of a petition to Family Court.

- For VCM cases, if a family refuses to accept services or is non-compliant, the case is returned to CWS for further investigation.

- For FSS cases, if the family refuses to engage in services, CWS is notified and in most cases no further action will be taken.

- If FSS assesses that the risk level of a case is elevated to moderate/high risk, the case is returned to CWS for reassessment by intake and a referral to VCM or CWS.

Referrals to FSS/VCM may be made in the event the Department files a petition in Family Court and the Department, family, and the Court determine the family should be provided the opportunity to participate in voluntary services. In these cases, the petition can be dismissed, or set aside, and the case should then be referred to the appropriate program for services.

FSS Referral Criteria

- According to the intake or CWS worker's assessment, children are safe.

- Risk assessment indicates family does not have significant problems such as domestic violence, substance abuse, mental illness or developmental delays; or if any of these problems are present they do not threaten child safety, and the family has sufficient strengths and resources to deal with them through extended family and/or community resources.

- Minimum parenting standards are being met.

- In cases involving allegations of serious harm, the alleged perpetrator has no access to the child due to an existing court order, and/or the caregiver's protectiveness.

- Family may be facing some challenges, but these are not of an overwhelming nature and they do not endanger the child's immediate safety.

- The family has many strengths and resources and is able to deal with challenges and needs through involvement with extended family and/or community resources.

VCM Referral Criteria

- According to the intake assessment or assessment by CWS, children may be at risk for abuse or neglect. The factors presenting risk may be of a moderate to significant nature but can be controlled.

- Risk assessment indicates that family is facing challenges and needs that have an effect upon risk, including issues such as domestic violence, substance abuse, mental illness or developmental delays. However, these behaviors and conditions can be effectively controlled during intervention. The family has sufficient strengths and resources to learn to deal with them with the assistance of VCM intervention.

- The family is likely to have moderately complex child welfare needs, including past CWS history.

- Minimum parenting standards are not being met, but the parents seem capable of meeting minimum parenting standards on their own or with community-based services after intervention by the VCM program.

- There may be juvenile court involvement, or other court involvement, such as Temporary Restraining Orders.

- In referrals from CWS assessment, the family must be willing to participate voluntarily in services.

INTAKE

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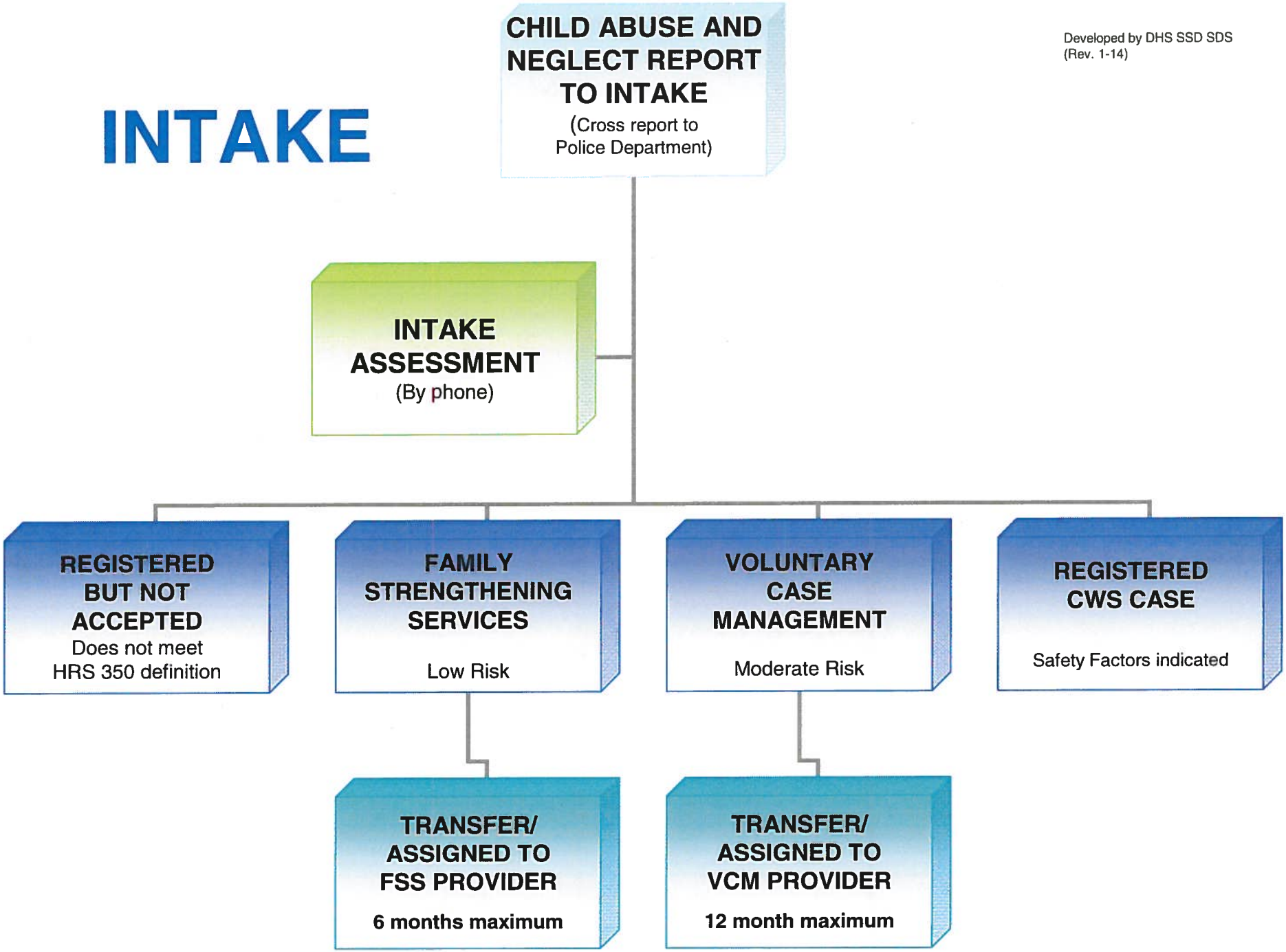

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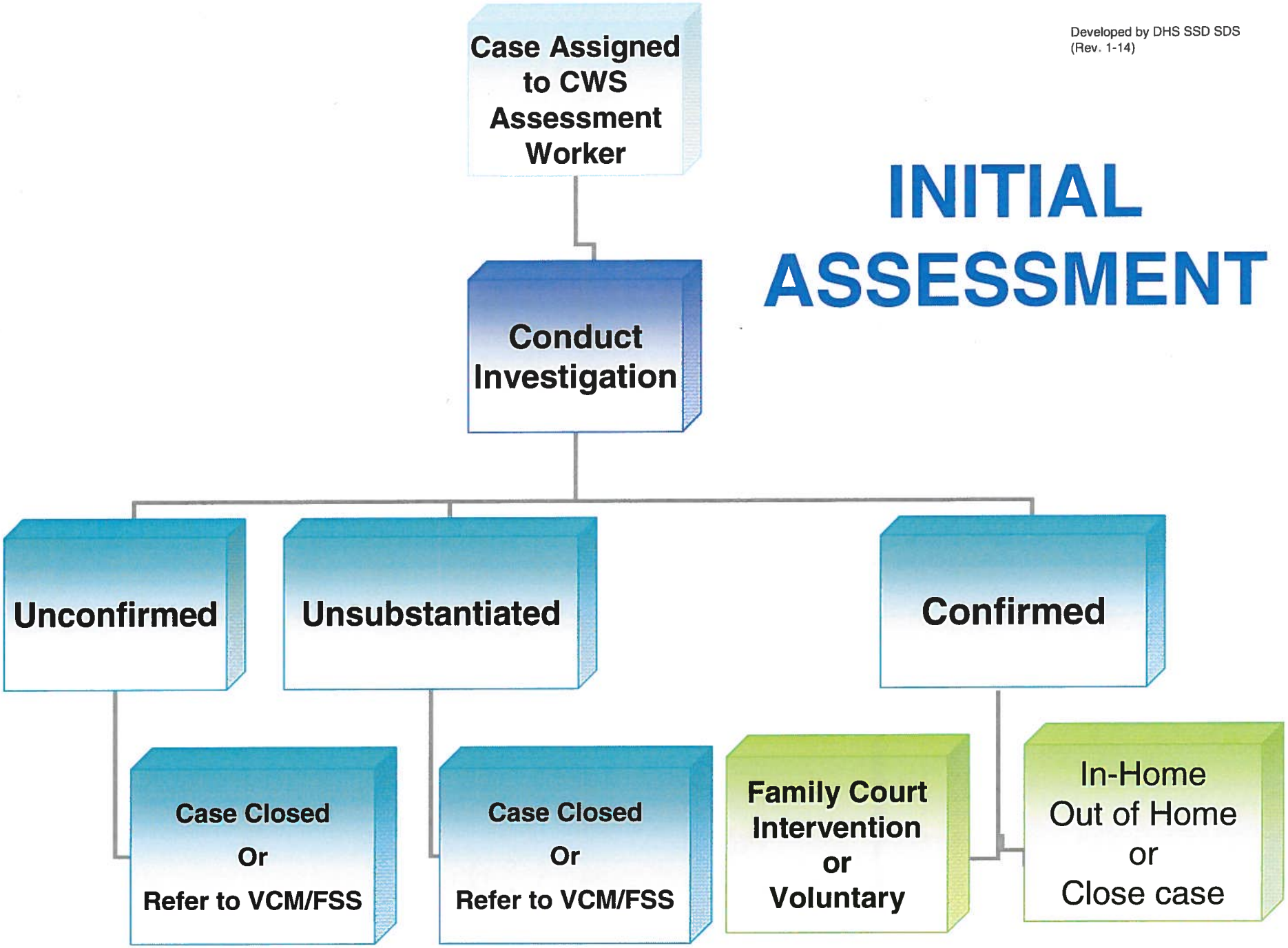
INITIAL ASSESSMENT



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CASE MANAGEMENT

Assign Case To Permanency Worker

Dispositional & Service Plan Hearing
If not done during initial assessment phase

Monitor & Evaluate Family Progress
12 mos. or 15 out of 22 mos.

Jurisdiction Terminated Case Closed

File Permanent Custody motion
Terminate Parental Rights

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PERMANENCY